

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Perry Registration District No. 660 File No. 2044  
Township Central Primary Registration District No. 5878 Registered No. 4  
City (No. St. Ward)

2. FULL NAME

Mrs. Philomine C. Emendorfer  
(a) Residence No. St. Ward. (If nonresident give city or town and State)  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OR (OR) WIFE OF Jos. Emendorfer  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 12 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
26 2 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perry County Mo

10. NAME OF FATHER Wm. C. Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Perry County Mo

12. MAIDEN NAME OF MOTHER Black

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Perry County Mo

14. INFORMANT Jos. Emendorfer  
(Address) R. 2, Perryville Mo.

15. FILED Jan 15, 1923 H. H. Papp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Jan 7th, 1923, but I last saw her alive on Jan 7th, 1923, and that death occurred, on the date stated above, at 9:30 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia following Influenza

CONTRIBUTORY (SECONDARY) Influenza

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) H. T. Barick, M. D.

(Address) Perryville Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

W. H. Hope Farm Jan 9 1923  
20. UNDERTAKER ADDRESS  
Phil A. Leuchel Perryville

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Perry  
Township Central  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of \_\_\_\_\_

Registered No. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mrs Philomine C. Emmendagen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M

6 DATE OF BIRTH X Oct 25 1896  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. ?  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)

PARENTS  
10 NAME OF FATHER \_\_\_\_\_  
11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_  
12 MAIDEN NAME OF MOTHER \_\_\_\_\_  
13 BIRTHPLACE OF MOTHER (State or country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

15 Filed 4/9 1913 Arthur Papp  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 7 1913  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
(SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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